

§ 424.505

sole proprietorship or organizational entity.

Reject/Rejected means that the provider or supplier's enrollment application was not processed due to incomplete information, or that additional information or corrected information was not received from the provider or supplier in a timely manner.

Revoke/Revocation means that the provider or supplier's billing privileges are terminated.

State oversight board means, for purposes of §§ 424.530(a)(15) and 424.535(a)(22) only, any State administrative body or organization, such as (but not limited to) a medical board, licensing agency, or accreditation body, that directly or indirectly oversees or regulates the provision of health care within the State.

Voluntary termination means that a provider or supplier, including an individual physician or nonphysician practitioner, submits written confirmation to CMS of its decision to discontinue enrollment in the Medicare program.

[71 FR 20776, Apr. 21, 2006, as amended at 73 FR 69939, Nov. 19, 2008; 75 FR 70464, Nov. 17, 2010; 75 FR 73628, Nov. 29, 2010; 76 FR 5962, Feb. 2, 2011; 79 FR 72531, Dec. 5, 2014; 82 FR 53368, Nov. 15, 2017; 84 FR 47852, Sept. 10, 2019; 84 FR 63203, Nov. 15, 2019; 86 FR 65682, Nov. 19, 2021; 87 FR 70231, Nov. 18, 2022]

§ 424.505 Basic enrollment requirement.

To receive payment for covered Medicare items or services from either Medicare (in the case of an assigned claim) or a Medicare beneficiary (in the case of an unassigned claim), a provider or supplier must be enrolled in the Medicare program. Except for those suppliers that complete the CMS-855O form or CMS-identified equivalent, successor form or process for the sole purpose of obtaining eligibility to order or certify Medicare-covered items and services; once enrolled the provider or supplier receives billing privileges and is issued a valid billing number effective for the date a claim was submitted for an item that was furnished or a service that was rendered. (See 45 CFR part 162 for information on the Na-

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tional Provider Identifier and its use as the Medicare billing number.)

[71 FR 20776, Apr. 21, 2006, as amended at 79 FR 72531, Dec. 5, 2014]

§ 424.506 National Provider Identifier (NPI) on all enrollment applications and claims.

(a) *Definition. Eligible professional* means any of the professionals specified in section 1848(k)(3)(B) of the Act.

(b) *Enrollment requirements.* (1) A provider or a supplier that is eligible for an NPI must do the following:

(i) Report its NPI on its Medicare enrollment application.

(ii) If the provider or supplier was in the Medicare program before obtaining an NPI and the provider's or the supplier's NPI is not in the provider's or supplier's Medicare enrollment record, the provider or supplier must update its Medicare enrollment record by submitting its NPI using either of the following:

(A) The applicable paper CMS-855 form.

(B) Internet-based PECOS.

(2) A physician or eligible professional who has validly opted-out of the Medicare program is not required to submit a Medicare enrollment application for any reason, including to order or certify.

(c) *Claims reporting requirements.* (1) A provider or supplier that is enrolled in Medicare and submits a paper or an electronic claim must include its NPI and the NPI(s) of any other provider(s) or supplier(s) identified on the claim.

(2) A Medicare beneficiary who submits a claim for service to Medicare—

(i) Must include the legal name of any provider or supplier who is required to be identified in that claim; and

(ii) May, if known to the beneficiary, include the National Provider Identifier (NPI) of any provider or supplier who is required to be identified in that claim.

(3) A Medicare contractor will reject a claim from a provider or a supplier if the required NPI(s) is not reported.

[75 FR 24448, May 5, 2010, as amended at 77 FR 25317, Apr. 27, 2012]